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BILL NO. HB 345

False Claims Act Revisions: House Bill 345

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I. WHAT IS THE FEDERAL FALSE CLAIMS ACT (FFCA)?

A. History: Passed in Response to contractors cheating the army during the Civil War.

B. Purpose: It is currently used to recuperate money fraudulently taken from the government via the use of claims for services/products that are fraudulent or knowingly false. It is unique in that both a private citizen with knowledge of fraud (known as a whistleblower or qui tam plaintiff) and/or the government can bring a lawsuit under the statute.

C. More Recently: The FCA was significantly strengthened in 1986 and is often used to sue companies that overcharge the Medicaid/Medicare/and other government funded healthcare programs. Often the allegations are that companies encourage Doctors to use their products in a way they weren't intended, which causes increased billing to the Medicaid program.

II. HOW DOES IT WORK?

The FCA encourages private citizens with knowledge of fraudulent activity to bring lawsuits on behalf of the Federal government. These people are called whistleblowers, relators, or qui tam plaintiffs. They are almost always insiders that have information not accessible to the government. They provide valuable insight into fraudulent activity.

Relators must give all information to the government who has 60 days to investigate and decide whether to join in the lawsuit or not (this time can be extended). Relator gets a certain percentage of the recovery, depending on whether the government intervenes or lets the Relator go it on his/her own.

III. HOW DOES MEDICAID WORK?

Medicaid was instituted in 1964, as was Medicare. Medicare is a wholly Federal program whereas Medicaid is a joint Federal/State program. Medicaid is generally designed to pay for health care on behalf of poor people. Each state designs and administers its own program subject to requirements of the Federal government (Centers for Medicare and Medicaid Services or CMS).

In addition to CMS, the State Medicaid programs and the State Medicaid Fraud Control Units are also monitored by United States Health and Human Services (HHS) and the Office of Inspector General (HHS-OIG).

IV. WHAT IS FMAP?

FMAP, or Federal medical assistance percentage, is the Federal share of the money paid on behalf of people on Medicaid. The percentage is different for each state, depending on the per capita income of people within the state. Currently the FMAP for MT is 66%/34% which means of every Medicaid dollar spent, 66% comes from the Federal government.

When money is recovered on behalf of a State for fraud to its Medicaid program, regardless of how the money is recovered—the FMAP portion must be repaid by the State to the Federal government.

V. THE MONTANA FALSE CLAIM ACT (MTFCA)

A. Why was it Enacted?: Lawsuits were being filed on the Federal level alleging that large pharmaceutical companies were cheating the Medicaid system. Recoveries (Millions of dollars) were being recovered, but the States weren't really being represented, since many had no false claim acts. Sometimes the Federal government would include the states, but not always. As a result, several states enacted State FCAs (including MT).

B. How is it Used?: Very similar to the FFCA, the State FCA is used to recover money taken from the government through the use of fraudulent or knowingly false claims. In most cases, it is used against pharmaceutical companies, health supply companies, durable medical equipment companies, etc. for submitting false claims or overcharging the Medicaid program. Since many schemes involve many states, and other federal healthcare programs (such as Medicare) there is often one nationwide lawsuit filed on behalf of the State's and the federal government.

VI. IMPACT OF THE DEFICIT REDUCTION ACT

In 2006, the US Congress passed the DRA of 2005. It created an incentive for States to pass their own FCAs to combat Medicaid fraud. Those states that pass a FCA that parallels the Federal FCA are entitled to keep an extra 10% of the recoveries from such lawsuits, which would have otherwise had to be paid back to the Federal government as part of the FMAP recovery requirement. Most States' (including MT) FCAs include whistleblower, or qui tam provisions.

For example: After deducting the whistleblower's share, $100,000 was recovered by a whistleblower on MT's behalf. Since MT's FMAP is 66%, $66,000 must be paid to the Federal government. With the DRA "bump" of 10%, the percentage becomes 56% or $56,000. By having a DRA compliant statute, MT gains $10,000.

VII. WHY DOES THE STATE FCA NEED TO COMPORT WITH THE FFCA?

One requirement of the DRA was that State FCAs had to be at least as effective in encouraging whistleblower lawsuits as the Federal False Claims Act. HHS-OIG was tasked with reviewing each State's FCA to determine whether it was at least as effective in encouraging whistleblower lawsuits as the Federal FCA. In 2011, OIG determined that MT's FCA was deficient in several areas. As such MT has not qualified for the 10% FMAP "bump." The current revisions are intended to correct that problem.

An informal review by HHS-OIG has indicated that if the recommended changes are made, MT's FCA will, in all likelihood, be found to be compliant.